

To be completed by voluntary worker

Personal Details

Surname

Given name/s

Postal address

Street or PO Box No.

Street name

Suburb

Postcode

State

Phone Private

Business

Fax

Mobile

Voluntary Worker's date of birth (dd/mm/yyyy)

Email address

Please complete if in paid employment at the time of the accident

1. Employers name

2. Employers address

3. Your normal weekly wages (excluding overtime)

4. Your usual occupation

5. Please give details of any weekly payments received during the period of disablement e.g. wages, compensation, social services etc.

6. Are you making or entitled to make any other insurance or compensation claim in respect to this disablement:

i) sick leave/annual

ii) workers compensation

What injury/injuries did you sustain?

Names and address of witnesses

1.

2.

Please advise name and address of doctor who treated you after the accident and details of treatment given

Have you lodged a claim through Private Health Insurance in relation to this claim?

YES NO

If YES, please provide all relevant proof of benefits paid by your health insurer.

This Personal Accident Voluntary Workers Policy will pay the difference between the Insured's non Medicare rebate and the cost of the service.

If you are totally disabled from attending your normal employment, please give dates of disablement:

from / / to / /

The original certificate from a qualified medical practitioner must be submitted for all periods of disablement claimed.

Please give details of any weekly payments received during the period of disablement (eg: wages, compensation, social services, etc.)

Please detail your non-Medicare related costs

Are you claiming for total disablement for domestic home duties?

YES NO

If YES, we require a medical certificate confirming the period you are unfit to perform domestic duties, receipts/invoices from the home help provider.

Authority for Medical Information

I hereby authorise Hospitals, Medical Practitioners and Specialists who treated me as a result of my injuries to provide medical information (including X-rays if appropriate) to Catholic Church Insurances Limited upon request in support of my claim for Policy benefits.

Declaration

I declare that the information given is true and correct, and that I suffered incapacity and/or expenses in the Accident referred to above.

Voluntary Worker's signature

Date

 / /

MUST BE COMPLETED BY CHURCH/SCHOOL/ORGANISATION (INCLUDING DECLARATION)

Policy number

Client number

Name of injured Voluntary Worker

Address

Postcode

Date of accident

 / /

Did the incident/personal injury/property damage occur during participation in, or attendance at, any WYD2008/DID08 or related event?

YES NO

Details of occurrence

Name of treating doctor

Address

Postcode

Give details of voluntary work being performed at the time of incident

Declaration

Do you consider the information on this form to be accurate? YES NO

If NO, please comment

Do you wish to make further comment in relation to this claim?

Church/school/organisation signature

Date

 / /

General Insurance Code of Practice

The General Insurance Industry has developed a General Insurance Code of Practice for use by all insurers. Catholic Church Insurances has adopted and enthusiastically supports the Code because it:

- requires the provision of high standards of good practice and service
- requires the provision of more relevant and useful information to consumers
- promotes understanding of your rights and obligations under our insurance contracts
- promotes informed and effective relationships between consumers, insurers and agents
- provides a process for the resolution of disputes.

The Code sets out what we must do when dealing with you through all stages of our relationship. If you want more information about the Code please contact us or go to www.codeofpractice.com.au.

If we are unable to provide you with insurance cover, we will:

- give you reasons; and
- refer you to the Financial Ombudsman Service for information about alternative insurance options.

If you are unhappy about our decision, you may make a complaint in accordance with our complaints handling procedures.

How to make a complaint

If our service fails to satisfy you we would like to hear from you.

Our commitment to you is that:

- all complaints will be dealt with fairly, transparently and in a timely manner
- we will acknowledge a verbal or written complaint within 5 business days
- our response will take no more than 15 business days.

Our complaints handling policy can be obtained from our website or by requesting a copy directly from us.

Your complaint will be handled by a person with the appropriate authority to deal with your complaint.

If you are not satisfied with our response, you may refer the complaint to our Internal Disputes Resolution Committee. This committee is a group of senior persons with the authority to make a final decision on behalf of the company.

Once your dispute has been through our Internal Disputes Resolution Committee and if you are still not satisfied you can refer your complaint to the Financial Ombudsman Service. Contact details for the FOS are as follows:

The Financial Ombudsman Service
Freecall: 1 300 78 08 08
Post: GPO Box 3,
Melbourne, Victoria 3001
Email: info@fos.org.au
Website: www.fos.org.au

The FOS is an independent insurance review body. Please note that the FOS will not accept a complaint unless you have first tried to resolve the problem with us.

If you prefer, you may pursue other options that may be available to you, such as consumer tribunals or legal process.

Safeguarding your information – Privacy

Privacy Statement

Catholic Church Insurances has adopted the National Privacy Principles under the Privacy Act 1988. This supports our management philosophy promoting mutual trust, respect, equity and fair treatment.

Purpose of collection

We need to collect personal information about you which enables us to assess your application for new insurance, change your existing insurance, correct your details or determine a claim.

Use and disclosure

To assess a risk or process a claim we may disclose your personal information when necessary to others, including loss assessors, claims investigators, reinsurers, other insurance companies, financial institutions, government bodies, mail house service providers, hospitals, medical and health professionals, legal and other professional advisors. Where necessary we will always gain your consent.

From time to time we may offer you other insurance products apart from your original policy. If you do not wish to receive this information please advise us.

You may access, correct or update your personal information by contacting us at any time.

Failure to provide information

If you do not provide us with the requested personal information, we will not be able to consider your application or provide other insurance services.

If you have a Privacy issue, wish to obtain a copy of our Privacy Policy or make a complaint please contact us.

How to Contact Us

Mail	Catholic Church Insurances Limited GPO Box 180 Melbourne 3001
Email	claim@ccinsurances.com.au
Website	www.ccinsurances.com.au
Telephone	1300 655 001
Facsimile	03 9934 3468